MDR Tracking Number: M5-04-2321-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 3-26-04.

In accordance with Rule 133.308 (e), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The Commission received the medical dispute resolution request on 3-26-04, therefore the following date(s) of service are not timely and are not eligible for this review: 2-20-03 through 3-25-03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. The level iii office visit was **found** to be medically necessary. The hot-cold pack therapy, therapeutic exercises and group therapy **were not** found to be medically necessary.

On 6-15-04 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

- The carrier denied CPT Code 99080-73 with a V for unnecessary medical treatment based on a peer review, however, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter and, therefore, per Rule recommends reimbursement. Requester submitted relevant information to support delivery of service. Per 134.1(c) **recommend reimbursement of CPT Code 99080-73 for dates of service 4-21-03 for $15.00.**

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Findings and Decision and Order is hereby issued this 8th day of October, 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

May 21, 2004

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-04-2321-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: IRO 5055

Dear Ms. Lopez:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information from requestor: office notes, physical therapy notes, FCE & radiology report for 11/26/01 through 09/25/03.
Information from respondent: peer review of 05/30/02.

Clinical History:
The records indicate the patient sustained a strain/sprain injury on the job on ___. He was initially treated and was referred for a consultation, evaluation, and treatment of injuries he sustained at the time of his injury. An intensive evaluation was performed on 11/26/01, and an aggressive treatment program was begun and continued for an extended period of time. In addition, the patient was assigned a 10% impairment rating and placed at MMI by designated doctor on examination in early 2003

Disputed Services:
Hot/cold back therapy, therapeutic exercises, group therapy, level III office visits during the period of 04/02/03 through 04/21/03.

Decision:
The reviewer partially agrees with the determination of the insurance carrier. The hot/cold pack therapy, therapeutic exercises and group therapy during the period in dispute were not medically necessary. The level III office visits during the period in dispute were medically necessary in this case.

Rationale:
National Treatment Guidelines allow for treatment of this sort of injury, but not to the extent, frequency, and duration this patient received as a result of his on the job injury of ___. All services provided during the period of 4/02/03 through 4/21/03, with the exception of the level 3 office visit, were not medically necessary, usual, reasonable, or customary for the treatment of this patient's on the job injury approximately 1 year and 8 month post injury date. There is not sufficient documentation to justify the type of services that were rendered. The patient should have been released to a home exercise program with only an occasional office visit and follow-up evaluation to measure his progress. Given the fact the patient was placed at MMI and given 10% impairment rating, occasional office visits will be necessary; however, therapy that can be provided in a home environment or at a workout facility of his choice would provide sufficient strengthening, rehabilitation in order for the patient to be able to appropriately deal with his on the job injury.

Sincerely,